MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02652

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Manchester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Horatio Arthur Albaugh

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M.

6.(b) Name of ~~husband~~ or wife Mary J Albaugh
6.(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) July 8 - 1875

8. AGE: Years 71 | Months 7 | Days 29 | If less than one day ... hrs. ... min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Blacksmith

11. Industry or business

FATHER
12. Name Abraham Albaugh
13. Birthplace Md

MOTHER
14. Maiden name Sarah Burns
15. Birthplace Md

16. Informant Mrs Mary J Albaugh
Address Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-10-47 (month) (day) (year)

Cemetery or crematory Manchester
Location Carroll Co Md

18. Funeral director Edw C Tipton
Address Hampstead

19. March 9 (Date rec'd by registrar) 1947 Mrs W. P. Shaver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1947, at 3:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE James T Thorsch Deputy Medical Examiner M. D. or other
Address Baltimore Md Date signed 3-7-47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02653

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years, 6 months, 8 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2 years, 6 months, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6314 Beechwood Drive
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: WILLIAM HUNT BALL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3/15/24

8. AGE: Years	Months	Days	If less than one day
22	11	26	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: James E. Ball, Jr.
13. Birthplace: Brooklyn, New York
MOTHER 14. Maiden name: Gladys Hunt
15. Birthplace: Springfield, Ohio
16. Informant: Records, Springfield State Hospital
Address: Sykesville, Maryland
17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Mar. 13 1947 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Washington D. C.
18. Funeral director: C. H. Herr
Address: Sykesville Md.
19. Mar 12 1947 (Date rec'd by registrar) C. Harry Herr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/11 19 47 at 6:15 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/22 19 46, to 3/11 19 47
and that I last saw him alive on 3/11 19 47

Immediate cause of death	DURATION
Pulmonary tuberculosis	5 mo.
Due to:	
Due to:	
Other conditions: Psychosis Mental Deficiency, Imbecile level (Include pregnancy within 3 months of death)	20 years

Major findings of operations: Date of op.:
Autopsy results: Pulmonary tbc; Tuberculous peritonitis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichart, M.D.
M. D. or other
Address: Sykesville, Maryland Date signed: 3/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 6 — 02854

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll Co.
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About 5 years
Hospital, Institution, or street address where death occurred: 56 Carroll St.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 56 Carroll St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Favorite Bell

3.(b) Social Security Number: 216-03-9090

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Lillie Bernadine Bell
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 18. 1877

8. AGE:

Years	Months	Days	If less than one day
68	4	6	..... hrs. ..... min.

9. Birthplace: Fred Co. Ms-Cregerstown, Md.
(Town, county, and state)
10. Usual occupation: Mechanic
11. Industry or business: Farm implement Sales
FATHER 12. Name: John H. Bell
13. Birthplace: Fred Co. Md.?
MOTHER 14. Maiden name: Annie M. Favorite
15. Birthplace: Fred Co. Md?
16. Informant: Walter F. Bell
Address: 56 Carroll St. Westminster Md
17. Burial (Burial, cremation, or removal, Which?) Date thereof 3/26/47 (month) (day) (year)
Cemetery or crematory: Baldwin Cemetery
Location: Rural near Westminster Md.
18. Funeral director: J. E. Myers Jr.
Address: Westminster Md
19. 3/27/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24 19 47, at 12 30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 19 47, to March 24-47
and that I last saw h. alive on March 23 19 47

Immediate cause of death	DURATION
Myocarditis (chr)	
Nephritis (chr)	
Due to	
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings of operations: None Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. C. Jennette M.D.
Address: Westminster Md M. D., or other
Date signed 3-24-47

item #6 G403-8/21/68

Item # 6916 Adm G-403 8/23/68

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02655

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?: 1 month, 22 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: BC
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No.: 419 Watty Court (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: ELIJAH BROWN
3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: ~~Dorothy~~ ~~Daisy~~ Brown, Daisy
6.(c) If alive, give age: 23 years
7. Birth date of deceased (mo., day, yr.): March 7, 1912

8. AGE: Years	Months	Days	If less than one day
35	0	22	... hrs. ... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business:
FATHER 12. Name: Edward Brown
13. Birthplace: Anne Arundel Co., Md.
MOTHER 14. Maiden name: Rebecca Adams
15. Birthplace: Calvert Co., Md.
16. Informant: Dorothy Brown (wife)
Address: 419 Watty Court
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 2-1947 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cemetery
Location: Brooklyn
18. Funeral director: Wm Brooks Ringgold
Address: 1463 N. Carey St
19. 3/29 1947 (Date rec'd by registrar) Albert R. Swankham Registrar Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29, 1947, at 5.45 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb., 7th. 1947, to March 29, 1947
and that I last saw him alive on March 29, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. (M. D. or other)
Address: Henryton, Md. Date signed: 3/29/47

VS A15 9-45-15M

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1-25

2-740-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

02656

Reg. Diat. No. 760

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster #3
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural Westminster #3
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jessie Grace Cassell

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband ~~or wife~~ Edward A. Cassell
6.(c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) July 7 - 1881

8. AGE: Years	Months	Days	If less than one day
65	8	23	hrs. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Joseph Bowers
13. Birthplace Md.
MOTHER 14. Maiden name Margaret Barnhart
15. Birthplace Md.
16. Informant Edward A Cassell
Address 66½ Penn. Ave, Westminster Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 1st 1947 (month) (day) (year)
Cemetery or crematory Cassell Cemetery
Location Westminster, Md. #5-
18. Funeral director H. Bankard Son
Address Westminster Md.
19. 3/3 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~April~~ March 30 1947, at 3:45 P M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from ~~March~~ March 30 1947 to ~~April~~ March 31 1947 and that I last saw h~~e~~r alive on ~~April~~ March 30 1947

Immediate cause of death	DURATION
Cerebral hemorrhage.	
Due to Arteri Sclerotic C-V disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James T Shank M. D. or other
Address Westminster Md Date signed 3/31/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

02657 P

13 Reg. Dist. No. 7X

1. PLACE OF DEATH:
County: Carroll
City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs. 4 mons. 12 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 8 yrs. 4 mons. 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2215 E. Fayette Street
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Edward Christopher

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Nora N. Covay
6.(c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): December 31, 1867

8. AGE: Years	Months	Days	If less than one day
79	2	21	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Carpenter (Retired)
11. Industry or business:

FATHER
12. Name: James Christopher
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah C. Garey (Baker)
15. Birthplace: Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/24/47 (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Frederick Rd. Baltimore, Md.

18. Funeral director: George J. Ruth, Inc.
Address: 1735 Harford Avenue

19. 3/24/47 (Date rec'd by registrar) Geo. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22, 1947 at 5:15a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1943, to March 22, 1947 and that I last saw him alive on March 21, 1947

Immediate cause of death	DURATION
Arteriosclerosis	10 yrs.
Due to	
Due to	
Other conditions: Psychosis with cerebral arteriosclerosis	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D. M. D. or other
Address: Springfield State Hospital Sykesville, Maryland Date signed: 3/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for the addition of place of residence and age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47 02658

HLM No. G 109 APR 14 1947 CERTIFICATE OF DEATH

Reg. Diat. No. 8/0

1. PLACE OF DEATH

County: Carroll Co

City or town: Near New Windsor Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Izaiah Demmitt

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widow

6.(b) Name of husband or wife: Emma Demmitt

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1865.

8. AGE: Years 82 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: James D. Demmitt

13. Birthplace: Maryland

MOTHER 14. Maiden name: Katherine Elizabeth Richards

15. Birthplace: Maryland

18. Informant: Jane A. Demmitt

Address: 231 Hudson St York Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-1-47 (month) (day) (year)

Cemetery or crematory: Pipe Creek Cemetery

Location: Near Unionstown, Md.

18. Funeral director: Raymond T. Wright

Address: Union Bridge, Md.

19. March 31 1947 Leslie D. Repp
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 1947, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 1947, to March 30 1947, and that I last saw him alive on March 26 1947.

Immediate cause of death	DURATION
arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: D. H. Legg. M. D. or other

Address: Union Bridge Date signed: 3-31-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02659

Reg. Diat. No. 74 | 136

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 28 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: BC

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1031 N. Eutaw Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: WALTER DICKENS

3.(b) Social Security Number: 218-10-7581

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 18, 1910

8. AGE: Years	Months	Days	If less than one day
36	9	13	hrs. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Jacob Dickens

13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Roxie Foreman

15. Birthplace: North Carolina

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/3/47 (month) (day) (year)

Cemetery or crematory: Mt Calvary Cemetery

Location: Annapolis Co

18. Funeral director: Chas H. Abbott

Address: 1200 N Calhoun St

19. 3/31 (Date rec'd by registrar) 19 47 Albert R. Greenberg Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31, 1947, at 4.50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb., 3, 1947, to March 31, 1947

and that I last saw him alive on March 31, 1947

Immediate cause of death	DURATION
PulMonary Tuberculosis	Dec. 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben M Fraser, M. D. M. D. or other

Address: Henryton, Md. Date signed: 3/31/47

1-25

2-740-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02660

Reg. Dist. No. 870

1. PLACE OF DEATH:
County: Carroll
City or town: Mt. Airy Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Mt. Airy Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME NANNIE A. DIETRICH

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: Philip Dietrich
deceased
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 5, 1858

8. AGE: Years 89 | Months 2 | Days 25 | If less than one day: hrs. min.

9. Birthplace: Frederick Co. Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Thomas A. Hyatt
13. Birthplace: Maryland

MOTHER
14. Maiden name: Alcinda Mosley
15. Birthplace: Maryland

16. Informant: Mrs. Ira Watkins
Address: Mt. Airy Md.

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 4-2-1947 (month) (day) (year)
Cemetery ~~or crematory~~: Prospect
near Mt Airy Frederick Co. Md.
Location

18. Funeral director: C. M. Wallis
Address: Winfield Md.

19. Apr. 1 1947 Elmer D. Snyder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29 1947 at 11:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 3 1945 to March 29 1947 and that I last saw h.e.s. alive on March 2 1947

Immediate cause of death	DURATION
General debility from old age - 89 yrs 2 mos	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C M Van Poole M. D. or other
Address: Mt Airy Md Date signed: 3-31

VS A15

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-7

02661

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months, 21 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 9 months, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Clarence Bailey Diffenderfer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 15, 1884

8. AGE: Years	Months	Days	If less than one day
62	05	00	hrs. min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and state)
10. Usual occupation: truck farming
11. Industry or business

FATHER
12. Name: Henry Harrison Diffenderfer
13. Birthplace: Baltimore City, Maryland

MOTHER
14. Maiden name: Rosalie Bailey
15. Birthplace: Baltimore City, Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-20-47 (month) (day) (year)
Cemetery or crematory: Springfield Cemetery
Location: Sykesville, Md.
18. Funeral director: C. Harry Wees
Address: Sykesville, Md.
19. Mar. 17 1947 C. Harry Wees
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15 1947 at 5:55a.m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 26 1946 to March 15 1947 and that I last saw him alive on March 14 1947

Immediate cause of death	DURATION
Coronary occlusion	instant
Due to: arteriosclerosis	
Due to: Syphilis, late latent,	
less than	20 yrs.
Other conditions: Schizophrenia, paranoid type	40 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: See cause of death above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did Injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of Injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed 3-15-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02662

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 27 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Joppa
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Camp 98
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: VONZO DIXON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Ada Dixon
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 8, 1916

8. AGE: Years	Months	Days	If less than one day
30	7	21	hrs. min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Joe Dixon
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Emma Nasco
15. Birthplace: North Carolina

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-5-47 (month) (day) (year)
Cemetery or crematory: Valley N. C.
Location: N C

18. Funeral director: H. A. Williams
Address: 322 N Charles St

19. 3/29 (Date rec'd by registrar) 19 47 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29, 19 47 at 8.05P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb., 2, 19 47 to Mar., 29, 19 47 and that I last saw him alive on March 29, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Maureen M. Duncan, M. D.
M. D. or other
Address: Henryton, Md. Date signed: 3/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-25

2-740 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47d)

CERTIFICATE OF DEATH

02663

Reg. Dist. No. 79

1. PLACE OF DEATH:

County Carroll

City or town Keymar Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Keymar, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Archie Thomas Flohr

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Mary Ellen Flohr

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 23, 1887

8. AGE: Years	Months	Days	If less than one day
59	11	4	..... hrs. ..... min.

9. Birthplace Zora, Pa.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name George Flohr

13. Birthplace Pa.

MOTHER 14. Maiden name Sarah E. Reeves

15. Birthplace Pa.

16. Informant Mary E. Flohr

Address Keymar, R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 31, 1947 (month) (day) (year)

Cemetery or crematory Haugh's Mt. Zion

Location Near Ladiesburg, Md.

18. Funeral director C.O. FUSS & SON

Address Taneytown, Md.

19. Mar. 28 1947 (Date rec'd by registrar) James M. Powell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1947, at 12 Noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 1947, to March 27 1947 and that I last saw h.i.m. alive on March 21 1947

Immediate cause of death	DURATION
Cancer of the lung	5 Mon.
Due to	
Due to	
Other conditions Atelectasis - R. Lung	1 Month

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. S. McVaugh M. D.
M. D. or other

Address Taneytown, Md. Date signed 3/27/47

M

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VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87-2)

CERTIFICATE OF DEATH

02664

Reg. Dist. No. 74

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs., 4 mo., 10 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 6 yrs., 4 mo., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)
Street No.: 421 Venable Avenue (If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: George Washington Ford

3. (b) Social Security Number: 705-05-7424

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Claudia (Rice) Ford
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): January 23, 1886

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
61	1	17		

9. Birthplace: Baltimore City, Maryland (Town, county, and state)
10. Usual occupation: Investigator
11. Industry or business: railroad, B. & O.

FATHER
12. Name: Charles E. Ford
13. Birthplace: Scotland

MOTHER
14. Maiden name: Virginia Nunally
15. Birthplace: Virginia

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/12/47 (month) (day) (year)
Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Maryland

18. Funeral director: HENRY SANDER & SONS, INC
Address: NORTH AVE. & BROADWAY

19. 3/13/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10, 1947, at 5:10A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1, 1943, to March 10, 1947
and that I last saw him alive on March 9, 1947

Immediate cause of death	DURATION
Huntington's Chorea,	
more than	18 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M.D. or other
Address: Sykesville, Maryland Date signed: 3-10-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (54)

CERTIFICATE OF DEATH

Reg. Dist. No. 02665 740

1. PLACE OF DEATH:

County: CARROLL

City or town: SYKESVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 MONTH, 29 DAYS

Hospital, Institution, or street address where death occurred:
SPRINGFIELD STATE HOSPITAL

How long in hospital or institution? 1 MONTH, 29 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 100 East Green Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Augusta Jane Frank

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: William P. Frank

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): 3/20/85

8. AGE: Years	Months	Days	If less than one day
61	11	16	...hrs. ...min.

9. Birthplace: Carroll County, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John Elias Houck
13. Birthplace: Carroll County, Maryland

MOTHER
14. Maiden name: Annie C. Arbaugh
15. Birthplace: Carroll County, Maryland

16. Informant: Records, Springfield State Hospital
Address: Sykesville, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Mar. 8, 1947
(month) (day) (year)

Cemetery or crematory: Carrollton

Location: Carrollton, Md.

18. Funeral director: H. Bankard & Son

Address: Westminster, Md.

19. Mar. 6 1947 C. Harry Keen
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/6 19 47 at 1:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/7 19 47 to 3/6 19 47 and that I last saw her alive on 3/6/47 19...

Immediate cause of death	DURATION
Carcinoma of Brain	9 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D.
M. D. or other

Address: Sykesville, Maryland Date signed: 3/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

(159)

02666

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF ~~STILLBIRTH~~ Birth & Death

Reg. Dist. No. 82

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:
   County: Carroll
   City or town: Mt Airy
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution:
   Length of mother's stay in County:
   (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:
   State: maryland
   County: Carroll
   City or town: Mt Airy
   (If outside city or town limits, write RURAL and give nearest town)
   Street No.:
   (If RURAL give LOCATION)

3. Name of child: Larry Austin Fritz
4. Date of birth: Mar 14 1947 Hour: 11 45 P.M.
5. Sex: m
6. Twin or triplet: no
7. No. of weeks pregnancy: 28

FATHER OF CHILD

8. Full name: Aubrey A Fritz
9. Color: w
10. Age at time of this birth: 27 yrs.
11. Usual occupation: Laborer

MOTHER OF CHILD

12. Full maiden name: V. Virginia Gregg
13. Color: w
14. Age at time of this birth: 26 yrs.
15. Usual occupation: Housework

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 3
    (b) How many other children were born alive but are now dead? 1 (c) How many other children were *born* dead? 1

17. Did child die before labor? no During labor? no
18. ~~Pregnancy, complications of~~ 2½ hours after delivery
    Fuel Bread Formula
19. Labor: (a) Complications of
    (b) Induced? no
20. (a) Was there an operation for delivery? no
    (Yes or No)
    (b) State all operations, if any
    (c) Did child die before operation? no
    During operation? no 2½ hrs later 245 PM

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
    (a) Fetal causes none known
    (b) Maternal causes Prematurity cause unknown

22. I certify to the birth of this child who was born dead* on the date and hour above stated.
    Signature: C M Van Poole M.D.
    (Specify if M. D., midwife, or other)
    Address: Mt Airy Md

23. (a) Burial (b) Date thereof 3/15/47
    (Burial, cremation or removal) (month) (day) (year)
    (c) Cemetery or crematory: Pine Grove Cem.
24. (a) Funeral director: Family Disposal
    (b) Address

25. (a) Mar. 15/47 (b) Ethel D Snyder
    (Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
    Health Officer, per

* See Instruction C on stub.

V. S. A10

Child lived 2½ hours 245 PM 3-15-47

1-35

MARYLAND STATE
~~BALTIMORE CITY~~ HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 83 02007

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) ~~Baltimore City~~, Maryland
(b) Street address Morgan, Carroll Co.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in ~~Baltimore~~ (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Morgan
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rural - Woodbine
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles D. Bernroth

3 (b) If veteran, name war: Spanish American
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife: Ida Belle Bernroth
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) July 7, 1874

8. AGE: Years 72 | Months 8 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore City Md
(Town, county, and state)

10. Usual Occupation Produce Merchant
11. Industry or business retired

FATHER
12. Name George Bernroth
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Wise
15. Birthplace Maryland

16 (a) Informant Mrs Ida Belle Bernroth
(b) Address ~~Md~~ Woodbine Md

17 (a) Burial (Burial, ~~cremation, or removal~~)
(b) Date thereof 3-20-47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltimore National
Location Baltimore Md

18 (a) Funeral director C. M. Walt
(b) Address Winfield, Md.

19 (a) March 19 (Date rec'd by registrar) (b) Edna M. Hewitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 16 1947, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946 to 3-16 1947
and that I last saw h[illegible] alive on 3-16 1947

Immediate cause of death — Duration

Cardiac vascular
Due to disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. A. Barnes, M.D.
Address Taylorsville, Md. Date signed 3-17-47

VS 150

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

02668

Reg. Dist. No. 760

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4712 7th Simmons Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: For [illegible] Region

3.(a) FULL NAME: Alfonso Grant

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Polish	Divorced

6.(b) Name of husband or wife: Annie Morgan

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Unk 1860

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
About 87				

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER 12. Name: Not known

13. Birthplace:

MOTHER 14. Maiden name: Not known

15. Birthplace:

16. Informant: Mrs. Irene Schaub

Address: Westminster # 4 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 12 - 1947 (month) (day) (year)

Cemetery or crematory: Meadow Ranch

Location: Westminster, Md.

18. Funeral director: H Bankard & Son

Address: Westminster Md.

19. 3/11 19 47 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10 19 47 at 8 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 46, to March 10 19 47

and that I last saw h... in alive on March 9 19 47

Immediate cause of death	DURATION
Myocarditis (chr)	
Nephritis (chr)	
Due to	
Due to	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. C. Jennett M.D. M. D. or other

Address: Westminster Md. Date signed: 3-11-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-6)

CERTIFICATE OF DEATH

02669

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
Springfield State Hospita l
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ?
City or town: ?
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Gray

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S X

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 12/20/1889

8. AGE: Years	Months	Days	If less than one day
57	2	14	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Odd jobs
11. Industry or business
FATHER — 12. Name: John Thomas Gray
FATHER — 13. Birthplace: Maryland
MOTHER — 14. Maiden name: Mollie Hughes
MOTHER — 15. Birthplace: Maryland
16. Informant: Records, Springfield State Hosp
Address: Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 7, 1947 (month) (day) (year)
Cemetery or crematory: Springfield
Location: Sykesville, Md.
18. Funeral director: C.H. Weer
Address: Sykesville, Md.
19. Mar. 5 1947 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/4/ 1947 at 9:15A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/27 1947 to 3/4 1947
and that I last saw h. im alive on 3/4 1947

Immediate cause of death	DURATION
Pulmonary tuberculosis	4 mos.
Due to: Syphilitic meningo-encephalitis	4 yrs.
Due to:	
Due to:	
Other conditions: Chronic alcoholism	?

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other
Address: Sykesville, Maryland Date signed 3/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

02670

Reg. Dist. No. 740

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 10 mo. 7 da.

Hospital, institution, or street address (if not in hospital)

Springfield State Hospital

How long in hospital or institution? 1 yr. 10 mo. 7 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary Green

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife John Henry Green

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar. 3d 1877

8. AGE: Years 70 | Months 5 | Days 4 | If less than one day: hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at home

FATHER — 12. Name William Keeney

13. Birthplace Md

MOTHER — 14. Maiden name Clara Elizabeth Fogel

15. Birthplace Md

16. Informant Mrs Myrtle Hamel

Address 3317 E St. SE Wash DC

17. Removal (Burial, cremation, or removal. Which?) Date thereof Mar. 8 1947 (month) (day) (year)

Cemetery or crematory

Location Washington, D. C.

18. Funeral director W. W. Chambers Co

Address Washington, D. C.

19. Mar. 8 1947 (Date rec'd by registrar) Harry Green Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1947 at 12-10 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1st 1945 to Mar 8 1947 and that I last saw him alive on Mar 8th 1947

Immediate cause of death Cerebral Hemorrhage — DURATION 2 da

Due to Arterio Sclerosis — DURATION 10 yrs

Due to Hypertension — DURATION

Due to Diabetes Mellitus — DURATION 6 yr

Other conditions — DURATION

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Gaston MD M. D. or other

Address Sykesville Md Date signed 3/8/47

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124-P)

CERTIFICATE OF DEATH

02671

Reg. Dist. No. 830

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Day, Carroll Co.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 mo.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Woodbine.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary E. Grimes

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband ~~or wife~~: Thomas G. Grimes
6.(c) If alive, give age: 85 years
7. Birth date of deceased (mo., day, yr.): May 7, 1869

8. AGE: Years: 77 | Months: 9 | Days: 25 | If less than one day: hrs. min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: Grasaway Gosnell
13. Birthplace: Maryland
MOTHER 14. Maiden name: Susan Tanner
15. Birthplace: Maryland
16. Informant: Mrs. Thos. G. Grimes
Address: Woodbine, Md
17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 3-4-1947 (month) (day) (year)
Cemetery ~~or crematory~~: Morgan Chapel
Location: Day, Carroll Co. Maryland
18. Funeral director: C. M. Waltz
Address: Winfield, Md.
19. Mar 2 19 47 (Date rec'd by registrar) Edna M. Hewitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2 19 47 at 6:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 16 19 46, to March 2 19 47
and that I last saw h-- alive on Feb 28, 19 47

Immediate cause of death	DURATION
Ascites	2 mo
Due to: Atrophic Cirrhosis of liver	?
Other conditions: Marked arterio-sclerosis (Include pregnancy within 3 months of death)	?

Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Stanley Grabill M. D. or other
Address: Mt Airy, Md Date signed: 3/2/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-d)

02672

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 years, 5 months, 2 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 46 years, 5 months, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: WILHELMINA GURSKA (Alias Schultz)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1866

8. AGE:	Years	Months	Days	If less than one day
	81	unknown		hrs. min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: domestic

11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital records

Address: Springfield State Hospital

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Mar. 6 1947
(month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cemetery

Location: Sykesville, Md.

18. Funeral director: C.H. Weer

Address: Sykesville, Md.

19. Mar 5 1947 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3rd 1947, at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1st 1942, to March 3rd 1947 and that I last saw her alive on March 3rd 1947

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	10 years
Due to:	
Due to:	
Other conditions: Schizophrenia, paranoid type	50 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Irene H. Lehman, M.D.
M. D. or other

Address: Springfield State Hospital Date signed: 3-3-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

02673

CERTIFICATE OF DEATH

Reg. Dist. No. 741

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 6 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: ELIZABETH VIOLA HAGENS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: William Hagens
6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): April 11, 1922

8. AGE:	Years	Months	Days	If less than one day
	24	10	29	....hrs. ....min.

9. Birthplace: La Plata, Md.
(Town, county, and state)

10. Usual occupation: Cook

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Edna Mathews
15. Birthplace: Unknown

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal, which?) Date thereof Mar. 12 1947 (month) (day) (year)
Cemetery or crematory St. Peters Church
Location Waldorf Md

18. Funeral director Hunt & Ryon
Address Waldorf, Md.

19. March 10, 1947 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 19 47 at 3.25P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 4, 1946 to March 10, 1947 and that I last saw her alive on March 10, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE Reuben W. Swan, M. D.
M. D. or other
Address Henryton, Md Date signed 3/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25

2-740-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (80-6)

CERTIFICATE OF DEATH

* 02674

Reg. Dist. No. 7K

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yr., 1 mo., 18 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 3 yr., 1 mo., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Halethorpe
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 79 Oregon Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: William Hedrick Harman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 28 1914

8. AGE: Years: 32 Months: 7 Days: 9 If less than one day: hrs. min.

9. Birthplace: Baltimore Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: Frederick A. Harman
13. Birthplace: Baltimore Maryland

MOTHER
14. Maiden name: Annie D. Hedrick
15. Birthplace: Baltimore Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Mar. 11 1947 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: 3804 Frederick Ave. Baltimore Md

18. Funeral director: Miller & Lawrence
Address

19. 3/10 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9 1947 at 5:00a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 1944 to March 9 1947 and that I last saw him alive on March 8 1947

Immediate cause of death	DURATION
Unknown	
Due to	
Due to	
Other conditions: Post-encephalitic syndrome	life

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
M. D., or other

Address: Springfield State Hospital Sykesville, Maryland Date signed: 3-9-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02675

CERTIFICATE OF DEATH

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Manchester (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Manchester (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Emory Ellsworth Hassler

3.(b) Social Security Number: 213-12-7296

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of ~~husband~~ or wife: Maggie E Lambert

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): April 6 - 1894

8. AGE:

Years	Months	Days	If less than one day
52	11	22	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Farmer.

11. Industry or business

FATHER — 12. Name: Emory E Hassler

FATHER — 13. Birthplace: Md

MOTHER — 14. Maiden name: Mary E Brown

MOTHER — 15. Birthplace: Md

16. Informant: Wm. Hassler

Address: Westminster Md R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 31/47 (month) (day) (year)

Cemetery or crematory: Manchester

Location: Carroll Co. Md

18. Funeral director: Edw Tipton

Address: Hampstead Md

19. Mar. 31 1947 (Date rec'd by registrar) Mrs. W. P. S. Denner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 28 1947, at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 1946, to March 28 1947

and that I last saw him alive on March 28 1947

Immediate cause of death	DURATION
Chronic Myocarditis	?
Due to	
Due to	
Other conditions Bronchial Asthma Chr.	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: Jos. E Buckland M. D. or other

Address: Hampstead Md Date signed: 3-29-47

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

02676

Reg. Dist. No. 74 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 1 day

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 518 Aisquith Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MATTIE FINCH JACKSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Widow

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 5, 1906

8. AGE: Years	Months	Days	If less than one day
40	11	29	..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Bennett Finch

13. Birthplace Virginia

MOTHER 14. Maiden name Levan Saunder

15. Birthplace Virginia

16. Informant Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-8-47 (month) (day) (year)

Cemetery or crematory Balto. National Cem.

Location Baltimore

18. Funeral director Rayner Sanders

Address 1412 E. Preston St.

19. March 4, 1947 (Date rec'd by registrar) Allen R. Saunders Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4, 1947, at 5.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 3, 1947, to March 4, 1947 and that I last saw h...er alive on March 4, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1st 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Nelson W. Swan, M.D. M. D. or other

Address Henryton, Md. Date signed 3/4/47

1-25

2-740 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02677

Reg. Dist. No. 740

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs. 2 mon. 16 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 17 yrs. 2 mon. 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unk —
(If rural, give LOCATION)

2.(a) If veteran, name war: /

3.(a) FULL NAME: Henry G. Kessler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9/8/1868

8. AGE: Years	Months	Days	If less than one day
78	6	9	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Jeweler

11. Industry or business:

FATHER
12. Name: John Kessler
13. Birthplace: Marburg, Germany

MOTHER
14. Maiden name: Marie ~~—~~ ?
15. Birthplace: Baltimore City

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-20-47 (month) (day) (year)

Cemetery or crematory: Western Cemetery

Location: Balto. Md.

18. Funeral director: William Cook, Inc.

Address: 1217 St Paul St.

19. Mar. 18 1947 (Date rec'd by registrar) C. Harry Klee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17, 1947, at 9:20AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1943, to March 17, 1947 and that I last saw him alive on March 16, 1947

Immediate cause of death	DURATION
Senility	
Due to	
Due to	
Other conditions: Dementia praecox, hebephrenic type	56 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
M. D. or other

Address: Springfield State Hospital Sykesville, Maryland Date signed: 3/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

02678

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 21 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 308 N. Eden Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ETHEL ROBERTA KEYS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan., 25, 1926

8. AGE: Years	Months	Days	If less than one day
21	1	29	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business:

FATHER
12. Name: George Keys
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ethel Calvert
15. Birthplace: Maryland

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal, Which?) Date thereof 3/28/47 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cemetery
Location: Anne Arundel Co. Md.

18. Funeral director: Elroy O. Wilson
Address: 1000 Brantley ave. Balto. md.

19. March 24, 1947 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24, 1947, at 1.25A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb., 3, 1947, to March 24, 1947 and that I last saw her alive on March 24, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Fuman, M. D. (M. D. or other)
Address: Henryton, Md. Date signed: 3/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25

2-740-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-6)

CERTIFICATE OF DEATH

02679

Reg. Dist. No. 8 20

1. PLACE OF DEATH:
County: Carroll
City or town: Mt. Airy, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Mt. Airy Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Anthony L. Kimmel

3.(b) Social Security Number: 217-05-8213

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband~~ or wife: Ada L. Kimmel
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Jan. 4, 1890

8. AGE: Years: 57 Months: 2 Days: 27 If less than one day: hrs. min.

9. Birthplace: Frederick Co. Md.
(Town, county, and state)

10. Usual occupation: Tech. Laboratory

11. Industry or business: Dough Nut Corp.

FATHER
12. Name: Peter Kimmel
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Nannie Dickson
15. Birthplace: Maryland.

16. Informant: Mrs. Ada L. Kimmel
Address: Mt. Airy Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 14-2-1947 (month) (day) (year)
Cemetery or crematory: Pine Grove
Location: Mt Airy Md.

18. Funeral director: C. M. Valentine
Address: Westfield Md.

19. Apr. 1st. 1947 (Date rec'd by registrar) Thos. D. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31, 1947, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1946 to 3/31 1947 and that I last saw him alive on March 31, 1947

Immediate cause of death	DURATION
Secondary Anemia	6 mo.
Due to: Carcinoma of Bladder	2 yrs
Due to:	
Other conditions: General Metastiare	6 mo.

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Bladder
Date of op. 1946

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Stanley Grabill M. D. or other
Address: Monrovia Md Date signed 4/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

CERTIFICATE OF DEATH

Reg. Dist. No. 8 Cert. No. 02680

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 years, three months, 21 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 17 years, 3 months, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Margaret E. Knierim

3.(b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: --
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 7, 1875

8. AGE: Years	Months	Days	If less than one day
72	0	20	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: practical nurse
11. Industry or business

FATHER
12. Name: Nicholas Knierim
13. Birthplace: Germany

MOTHER
14. Maiden name: Catherine E. Schick
15. Birthplace: Germany

16. Informant: Hospital records
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/29/47 (month) (day) (year)
Cemetery or crematory: Western Cem.
Location: Baltimore, Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Baltimore, Md.

19. 3/28 19 47 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27, 1947 at 4.50 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 1942 to March 27, 1947 and that I last saw her alive on March 27, 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	3 days
Due to: arteriosclerosis	12 years
Due to:	
Other conditions: Schizophrenia, paranoid type	20 years

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irene Hickman, M.D. M. D. or other
Address: Springfield State Hospital Date signed: 3-27-47

02681

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74a

CERTIFICATE OF DEATH

Reg. Dist. No. 7-0

1. PLACE OF DEATH:
County: Carroll
City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural - Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Mt. Pleasant Valley
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Jeremiah T. Koontz

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Flora Wantz Koontz
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 21, 1862

8. AGE: Years	Months	Days	If less than one day
84	5	4	hrs. min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business

FATHER
12. Name: Amos J. Koontz
13. Birthplace: Md

MOTHER
14. Maiden name: Savilla Starner
15. Birthplace: Md

16. Informant: Flora Wantz Koontz
Address: Westminster #R 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 28, 1947 (month) (day) (year)
Cemetery or crematory: St. Matthews
Location: Pleasant Valley, Md.
19. Funeral director: C. O. FUSS & SON
Address: Taneytown, Md.

19. 3/26 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25. 1947, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 47 to March 26. 1947 and that I last saw him alive on Mch 25. 1947

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. J. Stewart M. D.
Address: Westminster Md. Date signed: March 26 1947

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48)

CERTIFICATE OF DEATH

02682

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Rural Finksburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred:
Dale Home
How long in hospital or institution? 4 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Carroll
City or town: Rural Finksburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Arthur Lambert.

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6.(b) Name of husband or wife: Mary Lambert
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 14, 1874

8. AGE:	Years	Months	Days	If less than one day
	72	11	11	hrs. min.

9. Birthplace: Md
(Town, county, and state)

10. Usual occupation: Farm Labor

11. Industry or business:

FATHER
12. Name: Augustus Lambert
13. Birthplace: Md

MOTHER
14. Maiden name: Debbie Stultz
15. Birthplace: Md

16. Informant: Harry Lambert
Address: Union Bridge R#1

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/29/47 (month) (day) (year)
Cemetery or crematory: Mt. Union
Location: Middleburg Rural (Md)

18. Funeral director: C.O.FUSS & SON
Address: Taneytown, Md.

19. 3 29 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25 1947 at 5 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1940 to Mar 25 1947
and that I last saw him alive on March 25 1947

Immediate cause of death	DURATION
Carcinoma of stomach (Cachexia)	5 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: — Injured at work? —

23. SIGNATURE: James L. Gaspell M. D. or other
Address: Westminster Md Date signed 3-7-47

Mr. Mervyn [illegible] -
[illegible], Md

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

02683

Reg. Dist. No. 70

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Taneytown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 34 York Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Charles A. Lambert

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Anna Stewart

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): December 30, 1864

8. AGE: Years	Months	Days	If less than one day
82	2	12	____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Furniture repairing

11. Industry or business: own shop

FATHER
12. Name: Israel Lambert
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elizabeth Davidson
15. Birthplace: Unknown

16. Informant: Roy E. Lambert
Address: Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 16, 1947 (month) (day) (year)

Cemetery or crematory: United Brethern Cemetery

Location: Taneytown, Md.

18. Funeral director: C. O. Fuss & Son

Address: Taneytown, Md.

19 March 16, 1947 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14, 1947, at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 5, 1947, to March 14, 1947, and that I last saw h.i.m. alive on March 13, 1947.

	DURATION
Immediate cause of death: Uraemia	11 days
Due to: Chronic Nephritis, Arteriosclerotic Kidney	10 yrs.
Due to:	
Other conditions: Pernicious Arteriosclerosis, Hypertension, Chronic Myocarditis. (Include pregnancy within 3 months of death)	

Major findings of operations: None Done

Date of op.: ____

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of: ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. S. McVaugh M. D. M. D. or other

Address: Taneytown, Md. Date signed: 3/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 74 — 02684

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 1 mon. 25 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs. 1 mon. 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Frederick Lees

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: York -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 18, 1875

8. AGE: Years	Months	Days	If less than one day
71	8	19	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Barber

11. Industry or business:

FATHER — 12. Name: Christian Lees

FATHER — 13. Birthplace: York

MOTHER — 14. Maiden name: York

MOTHER — 15. Birthplace:

16. Informant: Springfield State Hosp. records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-11-47 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Balto. Md.

18. Funeral director: John F. Denny, Inc.

Address: Light & Montgomery Sts.

19. Md. 9 19 47 C. Harry Zeller (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7, 1947, at 9:07a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4, 1946, to March 7, 1947

and that I last saw him alive on March 6, 1947

	DURATION
Immediate cause of death: Chronic myocarditis and myocardial degeneration	10 yrs
Due to:	
Due to: Other - Arteriosclerosis	10 yrs
Other conditions: Psychosis with cerebral arteriosclerosis	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: see above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Howard N. Frederickson M.D.

M. D. or other

Address: Springfield State Hospital Sykesville, Maryland Date signed: 3-8-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

★ 02685

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 11 Bond
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth C. Little

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife Rufus Little
B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 25 - 1852

8. AGE: Years 94 | Months 4 | Days 1 | If less than one day ..... hrs. ..... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Adam Mason Simms
13. Birthplace Md.

MOTHER 14. Maiden name Sarah Harman
15. Birthplace Md.

16. Informant Miss Margaret Little
Address 11 Bond St. Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 29, 1947 (month) (day) (year)
Cemetery or crematory Mt. Carmel Cemetery
Location Littlestown, Pa.

18. Funeral director H. Bankard & Son
Address Westminster Md.

19. 3/28/47 (Date rec'd by registrar) H. Bankard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1947, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 14 1947 to March 26 1947
and that I last saw her alive on March 26 1947

Immediate cause of death	DURATION
Hypostatic Pneumonia	3 days
Due to Fracture left hip -	2 mos.
Due to Accidental fall. Cor. R.	
Other conditions Tripped over a rug in her bedroom.	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Accident Date of March 1st 1947
Where did injury occur? Westminster, (City or town) Carroll, (County) Maryland (State)
Injured at home, farm, industry, public place (where?) At home
Means of injury Accidental fall. Injured at work?

23. SIGNATURE Sheridan Rose (M.D.)
M. D. or other
Address Westminster Md. Date signed 3/27/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

02686

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73d)

CERTIFICATE OF DEATH

Reg. Dist. No. 260

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. W. Main
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ella B. Lloyd

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or ~~wife~~ Scott N. Lloyd
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 12 - 1864

8. AGE: Years	Months	Days	If less than one day
82	11	13	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name George W. Duvall
13. Birthplace Carroll Co. Md.
MOTHER 14. Maiden name Mary Cook
15. Birthplace Carroll Co. Md.
16. Informant Mrs. L. Albert Farver
Address Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 27-1947 (month) (day) (year)
Cemetery or crematory Stone Chapel Cemetery
Location Warfieldsburg, Md.
18. Funeral director H. Bankard Dorn
Address Westminster, Md.
19. 3/26/1947 (Date rec'd by registrar) L. Kuhn Duvall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25th 1947 at 2 P. M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 1st 1946 to Mar. 25th 1947
and that I last saw her alive on Mar. 24th 1947

Immediate cause of death	DURATION
Chronic Myocarditis	5 yrs
Due to Senility	
Due to	
Other conditions Polyarthritis and gallbladder disease (Include pregnancy within 3 months of death)	Several yrs

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. N. Billingsley M.D.
M. D. or other
Address Westminster, Md. Date signed 3-25-46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

02687

Reg. Diat. No. 8 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Mt Airy
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Mt Airy
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary M. Mathers

3.(b) Social Security Number

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Ulyne Mayer
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Oct. 12, 1864
8. AGE: Years: 82 Months: 6 Days: 18 If less than one day ..... hrs. ..... min.
9. Birthplace: unknown (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business
FATHER 12. Name: Asbury Burdett
13. Birthplace: unknown
MOTHER 14. Maiden name: Elizabeth Becroft
15. Birthplace: unknown
16. Informant: John Bennett
Address: 45 E. Fifth St. Frederick
17. Burial (Burial, cremation, or removal: Which?) Date thereof April 1, 1947 (month) (day) (year)
Cemetery or crematory: Pine Grove
Location: Mt. Airy
18. Funeral director: H. M. Snyder
Address: Mt. Airy Md.
19. Mar 31 19 47 H. M. Snyder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30, 1947 at 2:40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23 1947 to March 30 1947
and that I last saw h. alive on March 30 1947

Immediate cause of death	DURATION
Senility	
Due to: Advanced Arteriosclerosis	7 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Stanley Grabill - M. D.
M. D. or other
Address: Mt Airy, Md Date signed 3/31/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

02688

Reg. Dist. No. 74

1. PLACE OF DEATH

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs 3 mos 22 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 3 yrs 3 mos

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Howard Co

City or town: Dennett Md Rd #1 (If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME Hoke Hoyer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Divorced

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 28 - 1880

8. AGE: Years	Months	Days	If less than one day
67	1	22	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Dependent

11. Industry or business:

FATHER 12. Name: Abraham Hoyer

FATHER 13. Birthplace: Virginia

MOTHER 14. Maiden name: Catherine Sink

MOTHER 15. Birthplace: Virginia

16. Informant: Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 26 1947 (month) (day) (year)

Cemetery or crematory: Red Land

Location: Red Land, Maryland

18. Funeral director: Clayton Bowles

Address: Lay Town ville Md.

19. Mar. 23 1947 (Date rec'd by registrar) Stacy Hess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 23d 1947, at 6-30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 28 1946, to Mar 23 1947

and that I last saw h... alive on Mar 23d 1947

Immediate cause of death	DURATION
Terminal Pneumonia	4 da
Due to: Cerebral Hemorrhage	2 wks
Due to: Epilepsy	38 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. L. Haston M.D. M. D. or other

Address: Sykesville Md Date signed: 3/23/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

02689

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville - Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Florence Mullican

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Thomas Mullican
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): May 5 - 1892

8. AGE: Years	Months	Days	If less than one day
54	10	15	...hrs. ...min.

9. Birthplace: Montgomery County
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Joseph Sinclair
13. Birthplace: Montgomery County

MOTHER
14. Maiden name: Rosanna Hamilton
15. Birthplace: Montgomery County

16. Informant: Thomas Mullican
Address: White Oak - Silver Spring - Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof 3-21-47 (month) (day) (year)

Cemetery or crematory
Location: Silver Spring, Md.

18. Funeral director: Warner Humphrey
Address: Silver Spring, Md.

19. Mar. 21 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20 19 47, at 2:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 19 47, to March 20 19 47
and that I last saw her alive on March 20 19 47

Immediate cause of death	DURATION
General Paresis	3 years
Due to	ago -
Due to	
Other conditions: Bronchopneumonia	24 hours

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Virginia Beyer M. D.
M. D. or other
Address: Sykesville, Md. Date signed 3-20-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-b)

CERTIFICATE OF DEATH

02690

Reg. Dist. No. 742

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Edward G. Muth Carroll
City or town: Anne Arundel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 12 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 month, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 710 Chesapeake Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Edward G. Muth

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Adelia B. Muth
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12/27/01

8. AGE: Years	Months	Days	If less than one day
45	2	7	hrs. min.

9. Birthplace: Chicago, Illinois (Town, county, and state)
10. Usual occupation: retired ensign
11. Industry or business: U.S. Naval Academy
FATHER 12. Name: Unknown
13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 18, 1947 (month) (day) (year)
Cemetery or crematory: Arlington Cemetery
Location: Arlington, Va.
18. Funeral director: John M. Taylor
Address: Annapolis, Md.
19. Mar. 15 19 47 (Date rec'd by registrar) C. Harry Weir Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/14/ 19 47 at 8:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/7/ 19 47 to 3/14 19 47
and that I last saw him alive on 3/14 19 47

Immediate cause of death	DURATION
Pulmonary tuberculosis	4 mos.
Due to:	
Due to:	
Other conditions: Schizophrenia, paranoid type	20 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Ilse Kamm M. D. or other
Address: SPRINGFIELD STATE HOSPITAL Sykesville, Maryland Date signed: 3/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 0269183 0

Reg. Diat. No. 74

1. PLACE OF DEATH: Carroll

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Jacob C. Norwood

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Effie D. Norwood deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 31, 1868

8. AGE: Years: 78 | Months: 4 | Days: 9 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Frederick Co. Md (Town, county, and state)

10. Usual occupation: Farmer (retired)

11. Industry or business

FATHER — 12. Name: Not Known

FATHER — 13. Birthplace

MOTHER — 14. Maiden name: Not Known

MOTHER — 15. Birthplace

16. Informant: Mr. D. Conaway

Address: 150 N. Monastery Ave. Baltimore Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-13-47 (month) (day) (year)

Cemetery or crematory: Hyattstown

Location: Hyattstown, Frederick Co. Md

18. Funeral director: C. W. Waltz

Address: Winfield, Md

19. Mar 12 1947 (Date rec'd by registrar) Edna Hare Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10-1947 SV M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1944, to Mar 10 1947

and that I last saw him alive on Mar 8 1947

Immediate cause of death	DURATION
Cardio Vascular disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W H Barnes MD M. D. or other

Address: Ivy Rockville Md Date signed 3/11/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

02692

Bc

Reg. Dist. No. 740

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs. 3 mths. 6 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 6 yrs. 3 mths. 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 114 South Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME ELLA OTTENHEIMER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 14, 1881

8. AGE: Years	Months	Days	If less than one day
66	1	20	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Saleslady

11. Industry or business

FATHER
12. Name Lewis Ottenheimer
13. Birthplace Germany

MOTHER
14. Maiden name Rachel Feldenheimer
15. Birthplace Germany

16. Informant Hospital records

Address Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/7/47 (month) (day) (year)

Cemetery or crematory Hebrew Friendship

Location Balto. Md.

18. Funeral director David Sondheim & Son

Address 1902 Eutaw Place

19. Mar. 6 19 47 Stacy Keen
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6th 19 47, at 2:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1st 19 42, to March 6th 19 47

and that I last saw her alive on March 6th 19 47

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to XX Fracture of the right femur	18 days
Due to Accidental fall, during an epileptic attack, Cwg.	
Other conditions Alzheimer's disease	9 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE June H Lehman M.D
M. D. or other

Address Springfield State Hospital Date signed 3-6-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02693

Reg. Dist. No. 7H

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yr., 6 mo., 17 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 8 yr., 6 mo., 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 246 E. 7th. Street

(If rural, give LOCATION)

2.(a) If veteran, name war: none ✓

3.(a) FULL NAME: Harvey Winfield Peddicord

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 8-19-1892

8. AGE: Years	Months	Days	If less than one day
54(?)	6	26	...hrs. ...min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business:

FATHER — 12. Name: William Luther Peddicord

13. Birthplace: Thurmont, Maryland

MOTHER — 14. Maiden name: Mary Ellen Wolfe

15. Birthplace: Foxville, Maryland

16. Informant: Springfield State Hosp. records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-20-1947 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: La Gore, Md.

18. Funeral director: C. E. Cline & Son

Address: Frederick - Md.

19. Mar. 18 1947 (Date rec'd by registrar) C. Henry Ware Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17 1947 at 7:40p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to March 17 1947 and that I last saw him alive on March 17 1947

Immediate cause of death	DURATION
Pneumonia, etiology not determined	12 hrs.
Due to:	
Due to:	
Other conditions: Without Psychosis, Mental Deficiency (Include pregnancy within 3 months of death)	life

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.

Robert Bertrand May, M.D. M. D. or other

Address: Springfield State Hospital Sykesville, Maryland Date signed: 3-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

CERTIFICATE OF DEATH

Reg. Dist. No. 026983

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Rural-- Woodbine
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 48 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural--Woodbine Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: ELLA MAE PICKETT

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband ~~or wife~~: Sewell T. Pickett
deceased
(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 8, 1879

8. AGE: Years	Months	Days	If less than one day
67	10	6	hrs. min.

9. Birthplace: Howard Co. Maryland
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business

FATHER
12. Name: James Britton
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Gaither
15. Birthplace: Maryland

16. Informant: Mrs. Vernon Schafer
Address: Woodbine, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 3-17-47 (month) (day) (year)
Cemetery ~~or crematory~~: Morgan Chapel
Location: Day, Carroll Co. Maryland

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. March 16 19 47 (Date rec'd by registrar) Edna M. Hewitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14 19 47, at 4:20 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2 1946, to March 14 1947, and that I last saw h~~er~~ alive on 3/13/47 19.

	DURATION
Immediate cause of death: Metastasis to Lung	3 wks
Due to: Melino - carcinoma	3 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: Melino. Carcinoma of right buttock
Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Stanley Gaskill M. D. or other
Address: Mt Airy, Md Date signed 12/14/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8142

CERTIFICATE OF DEATH

02695

Reg. Diat. No.

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs. 1 mon. 18 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 35 yrs. 1 mon. 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: James Pokorney

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	mar

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1870

8. AGE: Years	Months	Days	If less than one day
77			hrs. min.

9. Birthplace: Austria
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: M. Jacob
13. Birthplace: Bohemia

MOTHER
14. Maiden name: Mary Frances
15. Birthplace: Bohemia

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 29th 1947 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Belair Road,

18. Funeral director: Lee D. Leach

Address: 1701-03 N Patterson Park Ave

19. March 28 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26, 1947, at 3:07 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1943, to March 26, 1947

and that I last saw him alive on 19

Immediate cause of death	DURATION
Manic-depressive psychosis	35 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Robert Bertrand May, M.D.
M. D. or other

Address: Springfield State Hospital Sykesville, Maryland Date signed: 3-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02696

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 years, 8 months, 13 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 32 years, 8 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: unknown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Salina Renner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 22, 1865

8. AGE: Years	Months	Days	If less than one day
81	7 months		hrs. min.

9. Birthplace: U.S.A. (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business

FATHER
12. Name: William Renner
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elizabeth Langman
15. Birthplace: Maryland

16. Informant: Hospital records
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-24-47 (month) (day) (year)
Cemetery or crematory: Lutheran Cemetery
Location: Middletown, Md.
18. Funeral director: Birdhill Co.
Address: Middletown, Md.

19. Mar 22 1947 (Date rec'd by registrar) Nancy Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21, 1947 at 12 noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 1942 to March 21, 1947 and that I last saw her alive on March 21, 1947

	DURATION
Immediate cause of death: Cerebral hemorrhage	10 days
Due to: arteriosclerosis about	15 years
Due to:	
Other conditions: schizophrenia about	34 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irene H. Hekman M.D. M. D. or other
Address: Springfield State Hospital Date signed: 3-21-47

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-2)

CERTIFICATE OF DEATH

02697

Reg. Dist. No. 760

1. PLACE OF DEATH:
County: Carroll
City or town: near Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos
Hospital, institution, or street address where death occurred: Israel Creek Alms House
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants, give residence of mother)
State: Maryland County: Carroll
City or town: near Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles M. Ridgely

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Annie Ridgely Deceased
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 9, 1861

8. AGE: Years: 85 | Months: 10 | Days: 27 | If less than one day: hrs. min.

9. Birthplace: Maryland (town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: Chas Ridgely
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: Unknown
16. Informant: Mrs. Lizzie Frieze
Address: Manchester Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-9-47 (month) (day) (year)
Cemetery or crematory: (Cemetery) Manchester
Location: Manchester Md
18. Funeral director: Jacob Winter's Sons
Address: Manchester Md.
19. (Date rec'd by registrar) 3-7 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 6th 1947 at [redacted] P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-15 1946, to 3-6 1947 and that I last saw h[redacted]live on 3-5-47 1947

Immediate cause of death	DURATION
Cardiac decompensation	5 days
Due to: Cirrhosis adhesions	years (?)
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: N. C. Hoover M. D. or other
Address: Westminster Date signed: 3-6-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02698

Reg. Dist. No. 740

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs. 10 mos., 20 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 5 yrs., 10 mos., 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: CATHERINE VIRGINIA ROWE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: John David Rowe

6.(c) If alive, give age: 33 (?) years

7. Birth date of deceased (mo., day, yr.): 4/14/18

8. AGE: Years	Months	Days	If less than one day
28	11	15	...hrs. ...min.

9. Birthplace: Hagerstown, Washington, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Frank W. Nield

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Margaret Heim

MOTHER 15. Birthplace: Maryland

16. Informant: Record, Springfield State Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 31-1947 (month) (day), (year)

Cemetery or crematory: Rose Hill cemetery

Location: Hagerstown Md

18. Funeral director: Scott & Munnich & Son

Address: Hagerstown Md.

19. Mar 30 1947 (Date rec'd by registrar) C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29 1947, at 2 00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9 1941, to March 29 1947 and that I last saw her alive on March 29 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 months
Due to	
Due to	
Other conditions: Schizophrenia, catatonic type	7 years.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Disseminated Pulmonary Tb; Tb. Enteritis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. M. D. or other

Address: Sykesville, Maryland Date signed: 3-29-47

1-35

Evidence for the addition of items 4,5, is shown on G 109 3/31/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

08699

Reg. Dist. No. 96

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 103 W. Green
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Jesse R. Sheats.

3. (b) Social Security Number 205-10-5629

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed

6.(b) Name of husband or wife Vera Pittinger
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 27 - 1878

8. AGE: Years	Months	Days	If less than one day
68	2	24	..... hrs. ..... min.

9. Birthplace Frizellburg, Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Clerk
11. Industry or business W. Md. Ry. Retired
FATHER 12. Name Abraham Sheats
13. Birthplace Carroll Co. Md.
MOTHER 14. Maiden name Sarah Catherine Gingling
15. Birthplace Carroll Co. Md.
16. Informant Mamie V. Bankard
Address 118 E. Main. Westminster Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 24-1947 (month) (day) (year)
Cemetery or crematory Rridenbaugh Cemetery
Location Westminster, Md
18. Funeral director H. Bankard Son
Address Westminster, Md.
19. 3-24 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1947 at about 3:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19.. and that I last saw h.. alive on ..... 19..

Immediate cause of death	DURATION
Coronary occlusion -	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James T. Monod Deputy Medical Examiner
M. D. or other
Address Westminster Md Date signed 3-22-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for the change of age is shown on G 109 4/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02700

FILM No. G 109 APR 14 1947

CERTIFICATE OF DEATH

Reg. Diat. No. 811

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William L. Spangler

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 12 1875

8. AGE: Years 71 72 | Months 85 | Days 28 | If less than one day ..... hrs. ..... min.

9. Birthplace Carroll County, Maryland (Town, county, and state)

10. Usual occupation Merchant

11. Industry or business Merchant Retired

FATHER 12. Name Hamilton Spangler

13. Birthplace Maryland

MOTHER 14. Maiden name Elizabeth Spangler

15. Birthplace Maryland

16. Informant Mrs. Paul Summers

Address Union Bridge, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 2-1947 (month) (day) (year)

Cemetery or crematory Mountain View Cemetery

Location Union Bridge, Maryland

18. Funeral director D D Hartzler & Sons

Address Union Bridge & New Windsor, Md

19. Apr. 2, 1947 (Date rec'd by registrar) M Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947, at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 24 1947, to 3-29- 1947 and that I last saw h... alive on 3-29- 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Legg M. D. or other

Address Union Bridge Date signed 3-31-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1—25—

2 - 810 —— 1—10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02701

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 27 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 677 Sarah Ann Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: HENRY STOKES

3.(b) Social Security Number: 216-09-5464

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Frances Stokes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 22, 1901

8. AGE: Years	Months	Days	If less than one day
45	8	24	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Brick Layer

11. Industry or business

FATHER
12. Name: Thomas Stokes
13. Birthplace: Virginia

MOTHER
14. Maiden name: Henrietta Watkins
15. Birthplace: Virginia

16. Informant: Deceasdd
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/22/47 (month) (day) (year)
Cemetery or crematory Mt Auburn
Location Balto Md
18. Funeral director Wm A. Jackson
Address 916 penna ave.
19. 3/18 19 47 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 19 47 at 10.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov., 19 19 46 to March 18, 19 47 and that I last saw h im alive on March 18, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben M Foman, M. D.
M. D. or other
Address Henryton, Md Date signed 3/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-740-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (65)

02702

CERTIFICATE OF DEATH

Reg. Diat. No. 801

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Carroll

City or town: New Windsor Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor R. D.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lillie Margaret Wachter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband ~~or wife~~: late Edward C. Wachter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 13 - 1880

8. AGE: Years: 66 | Months: 4 | Days: 11 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Frederick County, Md (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business

FATHER — 12. Name: Jacob Hauch

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary Jane Hauch

15. Birthplace: Maryland

18. Informant: Roland E. Wachter

Address: New Windsor, Md R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 26-1947 (month) (day) (year)

Cemetery or crematory: Haughs Cemetery

Location: Sykesville, Md.

18. Funeral director: C. O. Gaither & Sons

Address: Union Bridge & New Windsor, Md

19. Mar 26 '47 (Date rec'd by registrar) Carey Bridal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24 1947, at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 20 1947, to Mar 20 1947, and that I last saw h.. alive on March 20 1947.

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to: Senile Senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. A. Hugg M. D. or other

Address: Union Mills Md. Date signed: 3-25-47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02703

Reg. Dist. No. 720

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Carroll

City or town: Silver Run

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 14yr. 5 mo

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Maryland County: Carroll

City or town: Silver Run Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Martha E. Waltz

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: Rena Waltz deceased

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Nov. 2, 1862

8. AGE: Years: 84 Months: 5 Days: 1 If less than one day: ____ hrs. ____ min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: John W. Edmondson

13. Birthplace: Maryland

MOTHER 14. Maiden name: Eliza Smith

15. Birthplace: Maryland

16. Informant: Mrs. Bessie Shipley

Address: Silver Run Md

17. Burial (Burial, ~~cremation, or removal~~, Which?) Date thereof 3-5-1947 (month) (day) (year)

Cemetery or ~~crematory~~: Deer Park

Location: Snallwood, Carroll Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md

19 Mar. 5 1947 (Date rec'd by registrar) Calvin E. Bankert, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 – 1947, at 7.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__ to ____ 19__; and that I last saw her alive on but after death March 3 – 1947.

	DURATION
Immediate cause of death: acute cardiac dilatation	3 hrs
Due to: Chronic myocarditis	3 yrs
Due to: Arteriosclerosis	5 yrs
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Chas. R. Fouty M.D. M. D. or other

Address: Westminster Md. Date signed 3-4-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02704

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Somerset
City or town: Upper Hill (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: /

3.(a) FULL NAME: EUGENE HENRY WATERS

3.(b) Social Security Number: 213-24-2085

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): March 5, 1929

8. AGE: Years	Months	Days	If less than one day
18	0	1	..... hrs. ..... min.

9. Birthplace: Upper Hill, Md. (Town, county, and state)
10. Usual occupation: Scholar
11. Industry or business

FATHER
12. Name: Willie Waters
13. Birthplace: Maryland

MOTHER
14. Maiden name: Josephine Johnson
15. Birthplace: Maryland.

16. Informant: Willie Waters
Address: Upper Hill, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) 3 (day) 9 (year) 47
Cemetery or crematory: Edgemount
Location: Upper Hill Md
18. Funeral director: Chas H Ward
Address: Marion Md.

19. (Date rec'd by registrar) March 6, 1947 Albert R. Swarthout Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6, 1947, at 9.30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb., 24, 1947, to March 6, 1947
and that I last saw him alive on March 6, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Reuben W Fuman, M. D. (M. D. or other)
Address: Henryton, Md. Date signed: 3/6/47

1-25

2-740 ——— 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02705

CERTIFICATE OF DEATH

Reg. Diat. No. 790

1. PLACE OF DEATH:

County Carroll

City or town Keymar Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Keymar

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Annie C. Wilhide

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife Peter R. Wilhide

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 12, 1864

8. AGE: Years	Months	Days	If less than one day
82	9	14	..... hrs. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Edward Shorb

13. Birthplace Md

MOTHER 14. Maiden name Ella Martin

15. Birthplace Md

16. Informant Mrs. Frank P. Alexander

Address Keymar, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 29, 1947 (month) (day) (year)

Cemetery or crematory Keysville

Location Keysville, Md.

18. Funeral director C. O. FUSS & SON

Address Taneytown, Md.

19. Mar 28 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1947, at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 19 1947 to March 26 1947 and that I last saw h.e.r. alive on March 24 1947

Immediate cause of death	DURATION
Chronic Myocarditis	5 yrs.
Due to	
Due to	
Other conditions Pain Opthalmitis Pyelitis	1 Month 5 weeks

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. S. McVaugh M. D. M. D. or other

Address Taneytown, Md. Date signed 3/27/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-C)

CERTIFICATE OF DEATH

02706

Reg. Dist. No. Bc 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 15 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1032 Clay Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JUANITA ELIZABETH WILLIAMS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Married

6.(b) Name of husband or wife: Thomas L. Williams
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept., 21, 1923

8. AGE: Years	Months	Days	If less than one day
23	5	21	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: Issac Williams
13. Birthplace: Unknown

MOTHER
14. Maiden name: Annie Preston
15. Birthplace: Maryland.

16. Informant: Deceased
Address

17. Removal. (Burial, cremation, or removal. Which?) Date thereof Mar 18th 47 (month) (day) (year)
Cemetery or crematory Baltimore City Morgue.
Location Baltimore, City.
18. Funeral director Mrs. Frances A. Hensley.
Address 578 W. Biddle st.

19. 3/14 (Date rec'd by registrar) 19 47 Albert R. Leonhardt Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1947, at 10.20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan., 27, 1947, to Mar., 14, 1947 and that I last saw her alive on March 14, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben W Thomas, M.D. M. D. or other
Address Henryton, Md. Date signed 3/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-740 - 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02707

Reg. Diat. No. 211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Taneytown Maryland R.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Roy Gordon Winters

3.(b) Social Security Number 213-03-1018

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mrs. Mae Winters

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 28 - 1902

8. AGE: Years	Months	Days	If less than one day
44	5	10	hrs. min.

9. Birthplace Egypt Penna
(Town, county, and state)

10. Usual occupation Electrical Foreman

11. Industry or business Cement Plant

FATHER
12. Name Leslie Winters
13. Birthplace Penna

MOTHER
14. Maiden name Anna Naylor
15. Birthplace Penna

16. Informant Mrs. Mae Winters

Address Union Bridge, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 13 - 1947 (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Uniontown, Maryland

18. Funeral director D.D. Hartsler & Sons

Address Union Bridge & New Windsor, Md.

19. Mar. 12 1947 (Date rec'd by registrar) E. Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1947, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Myocardial Dilatation	few min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lewis T. Marsh Deputy Medical Examiner M. D. or other

Address Westminster Md. Date signed 7-11-47

2-25

2-810-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

* 02708 80

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME J. Harry Gingling

3. (b) Social Security Number 212-03-1495

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Married

6.(b) Name of ~~husband or~~ wife: Sarah Koontz Gingling

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 31-1872

8. AGE:

Years	Months	Days	If less than one day
74	4	0	..... hrs. ..... min.

9. Birthplace: Carroll County, Md.

(Town, county, and state)

10. Usual occupation: School janitor

11. Industry or business

FATHER

12. Name: John Gingling

13. Birthplace: Maryland

MOTHER

14. Maiden name: Penelope Fuss

15. Birthplace: Maryland

18. Informant: Mrs. Sarah Gingling

Address: New Windsor, Md.

17. Burial (Burial, cremation, or removal: Which?) Date thereof: March 6-1947 (month) (day) (year)

Cemetery or crematory: Winters Cemetery

Location: New Windsor, R. 1, Md.

18. Funeral director: H. H. Shriner & Sons

Address: Union Bridge & New Windsor Md.

19. March 4 1947 (Date rec'd by registrar) Ernest Bricker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3, 1947, at 8:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death: Coronary Occlusion — DURATION

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Lewis F. Marker Deputy Medical Examiner M. D. or other

Address: Westminster, Md. Date signed 3/3/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11-C)

CERTIFICATE OF DEATH

02709

Reg. Diat. No. 760

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 156 W. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Emma J. Yount

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: Walter B. Yount

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 10, 1866

8. AGE: Years	Months	Days	If less than one day
81	1	15	..... hrs. ..... min.

9. Birthplace: Cloverdale, Virginia (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Henry C. Eller

13. Birthplace: Not known

MOTHER — 14. Maiden name: " "

15. Birthplace: " "

18. Informant: Karl E. Yount

Address: Baltimore, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 3/28/47 (month) (day) (year)

Cemetery or crematory: Meadow Branch Cemetery

Location: near Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 3/26/47 (Date rec'd by Registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25 19 47, at 6 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 26 1946, to Mar 25 1947

and that I last saw her alive on Mar. 25 1947

Immediate cause of death	OURATION
acute Cardiac Dilatation	8 hrs
Due to Empyema Upper Lobe Left Lung	2 mos
Due to Bronchiectasis	12 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Lehas R Fouty M D

M. D. or other

Address: Westminster Md. Date signed 3-26-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02710 76

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Washington Ave. & Green St.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Levi W. Zahn

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Margaret J. Zahn
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): November 9, 1880

8. AGE: Years	Months	Days	If less than one day
66	4	8	...hrs. ...min.

9. Birthplace: Westminster, Md.
(Town, county, and state)
10. Usual occupation: Lunch room
11. Industry or business

FATHER
12. Name: John L. Zahn
13. Birthplace: Maryland

MOTHER
14. Maiden name: Eliza Hanley
15. Birthplace: Maryland

16. Informant: Mrs. Levi W. Zahn
Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 3/19/47 (month) (day) (year)
Cemetery or crematory: Krider's Cemetery
Location: Westminster, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 3/17/47 (Date rec'd by registrar) 19... (P) P. K. Wood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17 19 47, at 4 a. m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
art 1- 19 46, to Mar 17, 19 47
and that I last saw him alive on Mar 17, 19 47

Immediate cause of death	DURATION
Acute cardiac dilatation	6 hrs
Due to: Chronic Valvular Disease - Mitral Stenosis -	3 years
Due to: Chronic Interstitial Nephritis -	5 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: Chas R Fout MD M.D. or other
Address: Westminster Md Date signed: 3-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

02711

Reg. Dist. No. 760

1. PLACE OF DEATH:
County: Carroll Co.
City or town: Westminster Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Abt 30 years
Hospital, institution, or street address where death occurred: 205½ E. Main St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 205½ E. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Hattie Edna Zile

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: Arthur M. Zile
6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Aug 26, 1885

8. AGE: Years: 61 | Months: 6 | Days: 7 | If less than one day: ....hrs. ....min.

9. Birthplace: New Windsor Carroll Co. Md. (Town, county, and state)
10. Usual occupation: Home-Wife
11. Industry or business:
FATHER 12. Name: George Smith
13. Birthplace: Germany
MOTHER 14. Maiden name: Jennie Leach
15. Birthplace: Penna.?
16. Informant: Mrs. Arthur M. Zile
Address: 205½ E. Main St. Westminster Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 5/47 (month) (day) (year)
Cemetery or crematory: Westminster Cemetery
Location: Westminster, Md.
18. Funeral director: J. E. Myers Jr.
Address: Westminster Md.
19. 3/4 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 3rd 1947, at 12 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 23rd 1947, to Mar. 3rd 1947, and that I last saw h-- alive on Mar. 3rd 1947

Immediate cause of death	DURATION
Coronary Thrombosis	7 days
Due to:	
Diabetes	5 years
Due to (Attended her prior)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: V. L. Billingsley, M.D. M. D. or other
Address: Westminster, Md. Date signed: 3-3-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35